Form No. S. F. 3.

STANDARD FORM FOR
EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY

Approved by I. A. I. A. B. C.

FLORIDA INDUSTRIAL COMMISSION
TALLAHASSEE, FLORIDA

MARYLAND CASUALTY COMPANY
JACKSONVILLE CLAIM DIVISION
Suite 8-B, Atlantic National Bank Annex Bldg.,
JACKSONVILLE, -:- FLORIDA

State's Number For:	File: ..... Carrier: ..... Employer: .....

Carrier's File No. .....
(The spaces above not to be filled in by Employer)

If Employer's First Report of Injury did not show that the injured had returned to work, an Employer's Supplemental Report of Injury should be completed and filed immediately after return to work of the employee; or at the end of days. In the event of the death of the employee, this report should be filed immediately.

1. Name of Employer Newark Eagles Baseball Club
2. Office address: No. and St. 71 Crawford St. City or Town Newark State N.Jersey
3. Insured by MARYLAND CASUALTY COMPANY
4. Name of Injured (in full) Lary (First Name) Eugene (Middle Initial) Doby (Last Name)
5. Present address: No. and St. 285 Hamilton Ave. City or Town Patterson State N.J.
6. Date of Injury April 1st 19 46 Day of week Monday Hour of day ..... A. M. ..... P. M.
7. Date disability began ..... 19 ..... A. M. ..... P. M. .....
8. Has injured returned to work? yes If so, date and hour few days later A. M. ..... P. M.
9. Is injured person earning same wages as before injury? ..... If not, explain .....
10. If disability has not terminated, state probable date of termination of disability .....
11. Has injured died? ..... If so, date of death ..... A. M. ..... P. M.

The injured employee, Lary Eugene Doby, returned to work April 6th, 46. The accident was not serious, and was only reported because it was necessary to have an X*Ray picture taken to determine the extent of any injury. No claim for compensation is being entered.

Date of this report ..... Firm name .....

Signed by E. A. Manley Official Title Partner